

AMENDED IN SENATE JUNE 20, 2016

AMENDED IN ASSEMBLY JANUARY 21, 2016

AMENDED IN ASSEMBLY JANUARY 13, 2016

AMENDED IN ASSEMBLY JANUARY 4, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 508

**Introduced by Assembly Member Cristina Garcia
(Coauthor: Assembly Member Burke)**

February 23, 2015

An act to add Section 123237 to the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 508, as amended, Cristina Garcia. Public health: maternal health.

Existing law establishes the State Department of Public Health and sets forth its powers and duties, as specified. Existing law requires the department to maintain a program of maternal, child, and adolescent health.

~~This bill would require the department to prepare and submit to the Legislature an annual report on maternal mortality and morbidity in California, including an analysis of maternal deaths and severe maternal morbidity. The bill would also require the department, in order to develop accurate reports in a resource-efficient manner, to consider existing resources, including, among others, opportunities for partnerships with other entities and use of physician volunteers.~~

This bill would establish a maternal mortality review panel to conduct ongoing comprehensive, multidisciplinary reviews of maternal deaths

and severe maternal morbidity in California to identify factors associated with the deaths and make recommendations for system changes to improve health care services for women in this state. The bill would also make information, documents, proceedings, records, and opinions created, collected, or maintained by the maternity mortality review panel or the State Department of Public Health in support of the maternal mortality review panel confidential and not subject to public inspection, discovery, or introduction into evidence in any civil action. The bill would also prohibit any person in attendance at a meeting of the maternal mortality review panel or who participates in the creation, collection, or maintenance of the panel's information, documents, proceedings, records, or opinions to testify in any civil action as to the content of those proceedings or the panel's information, documents, records, or opinions. The bill would require the State Department of Public Health to review department available data to identify maternal deaths and would mandate health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professionals, and facilities licensed by the State Department of Public Health to provide documents, as specified, upon request of the department. The bill also requires the State Department of Public Health to prepare and submit to the Legislature a biennial report on maternal mortality in California based on the data collected.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 *SECTION 1. The Legislature finds and declares all of the*
- 2 *following:*
- 3 *(a) Between 2002 and 2006, the rates of maternal deaths and*
- 4 *severe complications doubled in both California and the United*
- 5 *States. For every maternal death, there are approximately 100*
- 6 *cases of severe complications as defined by the federal Centers*

1 *for Disease Control and Prevention. Severe complications occur*
2 *in nearly 2 percent of all California births.*

3 *(b) Not only are these deaths and severe complications*
4 *devastating for those affected families, but the cost to the state and*
5 *private payers is significant. The University of California at Los*
6 *Angeles studied the costs for maternal hemorrhage and*
7 *preeclampsia/hypertension, the two leading causes of preventable*
8 *maternal mortality and 80 percent of severe maternal morbidity.*
9 *The study estimates that these conditions together cost Medi-Cal*
10 *\$200 million every year.*

11 *(c) Information and data regarding maternal mortality and*
12 *morbidity provides a clearer understanding as to the causes and*
13 *can be used for guidance in quality improvement projects needed*
14 *to reduce or eliminate deaths and severe complications.*

15 *(d) Analysis using certificates of death alone has proven to be*
16 *an incomplete and inadequate window into the underlying causes*
17 *and assessment of maternal deaths and needs to be supplemented*
18 *with other material, including coroner's reports and medical*
19 *records.*

20 *(e) The federal Centers for Disease Control and Prevention*
21 *(CDC), the American Congress of Obstetricians and Gynecologists*
22 *(ACOG), and the Maternal Child Health Bureau (HRSA-MCHB)*
23 *all strongly encourage every state to form and support a*
24 *multi-disciplinary committee to annually review maternal deaths*
25 *in as timely a manner as possible. The CDC reports that 33 states*
26 *have instituted maternal mortality committees.*

27 *(f) California's over 500,000 annual births represent fully*
28 *one-eighth of all United States births (and maternal deaths).*
29 *Reviews of these cases represent an important resource for state*
30 *and national efforts to better understand and reverse the rising*
31 *rates of maternal mortality and morbidity.*

32 *(g) Data from prior California maternal mortality reviews have*
33 *been particularly useful for launching statewide improvement*
34 *projects to reduce maternal deaths led by the State Department of*
35 *Public Health and the California Maternal Quality Care*
36 *Collaborative. This act shall establish an ongoing*
37 *multi-disciplinary panel for maternal mortality and severe*
38 *morbidity reviews, including reports to the Legislature.*

39 *SEC. 2. Section 123237 is added to the Health and Safety Code,*
40 *to read:*

1 123237. (a) For the purposes of this section, “maternal
2 mortality” or “maternal death” means a death of a woman while
3 pregnant or within 42 days of delivering or following the end of
4 a pregnancy when the woman’s death is from medical causes,
5 including suicide, and is related to or aggravated by the pregnancy.
6 Cases meeting these criteria are currently estimated to total
7 between 70 and 90 cases each year. Additional deaths occurring
8 between 42 days and 1 year following delivery may be included
9 in these reviews if resources and time permit. “Severe maternal
10 morbidity” means major maternal complications, as defined by
11 the federal Centers for Disease Control and Prevention, occurring
12 during birth or within 42 days of delivery.

13 (b) A maternal mortality review panel is established to conduct
14 ongoing comprehensive, multidisciplinary reviews of maternal
15 deaths and severe maternal morbidity in California to identify
16 factors associated with the deaths and make recommendations for
17 system changes to improve health care services for women in this
18 state. A maternity care provider shall chair the panel. Members
19 of the panel shall be appointed by the director, must serve without
20 compensation, and may include, as a minimum:

- 21 (1) An obstetrician.
- 22 (2) A physician specializing in maternal fetal medicine.
- 23 (3) A neonatologist.
- 24 (4) A certified nurse-midwife.
- 25 (5) A labor and delivery nurse.
- 26 (6) An anesthesiologist.
- 27 (7) A representative from the department who works in the field
28 of maternal and child health.
- 29 (8) An epidemiologist with experience analyzing perinatal data.
- 30 (9) Other professionals determined by the department and the
31 committee chair to address specific case review topics by the
32 committee.

33 (c) The maternal mortality review panel shall conduct
34 multidisciplinary reviews of maternal mortality and severe
35 morbidity in California. The panel may not call witnesses or take
36 testimony from any individual involved in the investigation of a
37 maternal death or enforce any public health standard or criminal
38 law, or otherwise participate, in any legal proceeding relating to
39 a maternal death.

1 (d) (1) Information, documents, proceedings, records, and
2 opinions created, collected, or maintained by the maternity
3 mortality review panel or the department in support of the maternal
4 mortality review panel are confidential and are not subject to
5 public inspection or discovery or introduction into evidence in any
6 civil action.

7 (2) Any person who attends a meeting of the maternal mortality
8 review panel or who participates in the creation, collection, or
9 maintenance of the panel's information, documents, proceedings,
10 records, or opinions shall not testify in any civil action as to the
11 content of those proceedings, or the panel's information,
12 documents, records, or opinions. This paragraph does not prevent
13 a member of the panel from testifying in a civil action concerning
14 facts that form the basis for the panel's proceedings of which the
15 panel member has personal knowledge acquired independently of
16 the panel or that is public information.

17 (3) Any person who, in substantial good faith, participates as
18 a member of the maternal mortality review panel or provides
19 information to further the purposes of the maternal mortality
20 review panel may not be subject to an action for civil damages or
21 other relief as a result of the activity or its consequences.

22 (4) All meetings, proceedings, and deliberations of the maternal
23 mortality review panel may, at the discretion of the maternal
24 mortality review panel, be confidential and may be conducted in
25 executive session.

26 (5) The maternal mortality review panel and the director may
27 retain identifiable information regarding facilities where maternal
28 deaths occur, or from which the patient was transferred, and
29 geographic information on each case solely for the purposes of
30 trending and analysis over time. All individually identifiable
31 information shall be removed before any case is reviewed by the
32 panel.

33 (e) The department shall review department available data to
34 identify maternal deaths. To aid in determining whether a maternal
35 death was related to or aggravated by the pregnancy, and whether
36 it was preventable, the department has the authority to do both of
37 the following:

38 (1) Request and receive data for specific maternal deaths,
39 including, but not limited to, all medical records, autopsy reports,

1 *medical examiner reports, coroner's reports, and social service*
2 *records.*

3 *(2) Request and receive data, as described in paragraph (1),*
4 *from health care providers, health care facilities, clinics,*
5 *laboratories, medical examiners, coroners, professionals, and*
6 *facilities licensed by the department.*

7 *(f) Upon request by the department, health care providers,*
8 *health care facilities, clinics, laboratories, medical examiners,*
9 *coroners, professionals, and facilities licensed by the department*
10 *must provide all medical records, autopsy reports, medical*
11 *examiner reports, coroner's reports, social services records,*
12 *information, and other data requested for specific maternal deaths*
13 *as provided in this subdivision to the department.*

14 *(g) The panel shall also review severe maternal morbidity data*
15 *provided by either the department or the California Maternal*
16 *Quality Care Collaborative (CMQCC). This data shall be*
17 *aggregated and deidentified but indicate major causes of morbidity*
18 *and time trends.*

19 *(h) (1) Notwithstanding Section 10231.5 of the Government*
20 *Code, the department, as part of its work to advance and improve*
21 *California maternity care through data-driven quality*
22 *improvement, shall prepare and submit to the Legislature a*
23 *biennial report on maternal mortality in California based on the*
24 *data collected. The report shall protect the confidentiality of all*
25 *decedents and other participants involved in any incident. The*
26 *report shall be distributed publically to stimulate performance*
27 *improvement. Interim results may be shared with the CMQCC*
28 *quality improvement programs. The report shall include both the*
29 *following:*

30 *(A) A description of the maternal deaths reviewed by the panel*
31 *during the preceding twenty-four months, including statistics and*
32 *causes of maternal deaths presented in the aggregate. The report*
33 *must not disclose any identifying information of patients, decedents,*
34 *providers, and organizations involved.*

35 *(B) Evidence-based system changes and policy recommendations*
36 *to improve maternal outcomes and reduce preventable maternal*
37 *deaths in California.*

38 *(2) A report submitted pursuant to paragraph (1) shall be*
39 *submitted in compliance with Section 9795 of the Government*
40 *Code.*

(i) *The department may use Title V Block Grant Program funds to support these efforts and may apply for additional federal government and private foundation grants, as needed. The department may also accept private, foundation, city, county, or federal monies to implement this section.*

SEC. 3. *The Legislature finds and declares that Section 2 of this act, which adds Section 123237 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:*

In order to protect confidential information, documents, proceedings, records, and opinions created, collected, or maintained by the maternity mortality review panel or the department in support of the maternity mortality review panel, it is necessary that this act limit the public's right of access to that information.

~~SECTION 1. Section 123237 is added to the Health and Safety Code, to read:~~

~~123237. (a) Notwithstanding Section 10231.5 of the Government Code, the State Department of Public Health, as part of its work to advance and improve California maternity care through data-driven quality improvement, shall prepare and submit to the Legislature an annual report on maternal mortality and morbidity in California. The report shall include, but not be limited to, all of the following:~~

~~(1) An analysis of maternal deaths that includes both of the following:~~

~~(A) Case review of each death;~~

~~(B) Analysis of patient demographics, contributing factors, and underlying causes;~~

~~(2) An analysis of all cases of severe maternal morbidity, as defined by the federal Centers for Disease Control and Prevention, for which data collection is practicable, including analysis of patient demographics and underlying causes;~~

~~(3) Suggestions for improvements in care to reduce maternal death and severe maternal morbidity.~~

1 ~~(b) In order to develop accurate reports in a resource-efficient~~
2 ~~manner, the department shall consider existing resources, including,~~
3 ~~but not limited to, all of the following:~~
4 ~~(1) Existing data sources available to the department.~~
5 ~~(2) Opportunities for partnerships with entities engaged in~~
6 ~~maternal care quality measurement or improvement.~~
7 ~~(3) Use of physician volunteers or committees.~~
8 ~~(c) A report submitted pursuant to subdivision (a) shall be~~
9 ~~submitted in compliance with Section 9795 of the Government~~
10 ~~Code.~~